Prevention and Wellness Advisory Board

Ch. 224 of the Acts of 2012

DPH Public Health Council Room
August 19, 2013

Meeting Minutes

Meeting began at 1:05

Board Members present:
Bruce Cedar
Lori Cavanaugh
Keith Dunham
Peter Holden
Lisa Renee Holderby-Fox
Paula Johnson
Stephenie Lemon
Marylynn Ostrowski (via phone)
Karen Regan
Susan Servais
Cheryl Bartlett, Commissioner DPH
Ann Hwang, EOHHS, sitting in for John Polanowicz, Secretary EOHHS

Board Members not present:
Tobias Fisher
Cathy Hartman
David Hemenway
Heidi Porter

DPH and EOHHS Staff present:
Bonnie Andrews
Tom Land
Laura Nasuti

Welcome and introductory remarks by Commissioner Cheryl Bartlett

- Meeting called to order
- Introductions of Board members

Objectives—Commissioner Bartlett

- Review RFR outline
- Weigh in on final data elements and priority interventions
- Learn about
    - E-Referral System in development by DPH
    - Evaluation plan and expectations of grantees

Conducting Business—Commissioner Bartlett

- July 29th meeting minute approval
  - Ann Hwang's name spelled incorrectly
  - Motion to approve made by Peter Holden, seconded by multiple board members
  - Unanimous approval among those in attendance

Review of RFR Outline
Commissioner Bartlett

- Scope of awards
  - 6-12 awards in total
  - Year 1: roughly $250,000 per awardee – capacity building
  - Year 2: roughly $1.1-2.2 Million per awardee – ramping up implementation
  - Year 3: roughly $1.2-2.5 Million per awardee – bulk of work, implementation
  - Year 4: roughly $1.1-2.2 Million – moving toward sustainability
- Health conditions
  - Required: tobacco use, asthma (pediatric), hypertension, fall prevention (older adults); Expect all grantees to all of address these
  - Optional conditions: Obesity, diabetes, oral health, substance abuse
  - Other conditions: not add points to application, but applicants can propose others
- Also want to look at comorbidities, particularly mental health
- These are all areas where we expect to see an impact on short term savings
- Required Letter of Intent due Sept 19th
- Checklist of requirements and for lead and coordinating partners
- Partnership requirements: Anyone can be coordinating partner (lead), but need to have municipality as a partner (each municipality can only be in one application), community-based organization, clinical health provider
  - Evidence of strong partnerships include:
    - Demonstrated history of collaboration between partners
    - Defined roles for each partner organization
    - Documented joint decision-making process
    - Agreement on milestones and timeline for capacity-building
    - Budgets with funding distributed appropriately depending on role
- Benchmarks to move to implementation phase:
  - Build and maintain partnership and supporting infrastructure
  - Two year strategic plan for each of 12 interventions (one from each of the 4 priority conditions across community, clinical, and community-clinical linkage)
  - Staffing plan
  - Budget plan
  - E-referral plan and initial pilot – this is similar to the tobacco quitline where it is a proactive system, where a referral is made to quitline and then they are referred to appropriate community resources and followed up. Can target patients not following through on recommendations.
  - Annual workplan with 6 month reporting to DPH. Don't want to wait too long to see if awardees are not being successful

    - Continuous QI plan to adjust and assess resources
    - Sustainability plan – look at ROI and see that savings can be reinvested in prevention to sustain funding into the future and expand to other partnerships across the state
- Sustainability
    - Policy, system, environmental changes for each priority conditions – have the largest impact on populations as a whole
    - How to sustain these partnerships, alternative payment models and global payments that could fund prevention efforts in the future
    - Plan for continuing specific interventions beyond 2017, when we are due to report
- Scoring – two levels
    - First level is technical – specific, quantitative and qualitative metrics for quality, clarity, completeness of application
    - Second level is focused on the strength of the proposal; a qualitative look at applicants' ability to meet objectives they have set for themselves
    - Technical Review Scoring
        - 65% of total score is partnership and population (communities that will be served)
            - 25% is partnership
            - 40% is population
        - Health Interventions (20%) and Partnership Infrastructure (5%) for a total of 25%
        - Sustainability and Budget 10%
            - *Please note, there was discussion around these percentages during the meeting, as the slides presented were inaccurate. The corrected slides have been posted online, and the figures here reflect the correct percentages*
- Bidders conference to be held on September 12th

Questions from the Board regarding RFR

Lori Cavanaugh: Seems to me we could get applications we like because of the breadth of what they are doing, so would that be taken into account in the second review?

Tom Land: Yes, the overall strength of the proposal and alignment with needs of catchment area will be reviewed. If they provided evidence that there was a need in the area and they were broad, that is okay.

Stephenie Lemon: I have a question around the expected level of integration. There are 4 key priority conditions, and enormous emphasis on population. So to what degree is integration important when the target populations could be so different? What kind of guidance are you going to give around integrating the different populations who will be served?

Tom Land: The primary goal is maximizing ROI, so we chose interventions we think will do best. Within that, we are trying to address the whole lifespan – pediatric asthma and falls are bookends and tobacco and hypertension are more in the middle. So if grantees are effective in the community-clinical linkage, the integration will take place primarily in the clinical system.

Marylynn Ostrowski: Kudos to those that put this together. I would like to see more emphasis on prevention. Can we have some sort of evaluative review of RFPs that focuses on what are we doing around prevention for these conditions?

Commissioner Bartlett: In addition to the secondary and tertiary focus in applications, we would like to see a prevention component too.

Paula Johnson: We need to see how these interventions, which could be quite medical, integrate with community. How do we create infrastructure that is sustainable? Public health departments will be critical to success. How do we ensure they have a real stake in the proposals? Might they sign off? Or be engaged in the proposal as it is submitted to us? I can imagine various proposals with many partners, but how does that work in terms of our thinking about the proposals?

Commissioner Bartlett: Depending on which municipalities are involved in this, some Boards of Health are primarily inspectional services only and others much more involved in their communities. We have to think about how to look at that.

Tom Land: We heard that at listening sessions again and again, so we tried to write language that required municipal participation, but not necessarily as the central role or applicant.

Paula Johnson: It will be important for us to know who comes in from which category.

Commissioner Bartlett: It does not preclude a health department from being the lead. We will be sure to emphasize that at the bidders' conference.

Keith Dunham: My first question is around the range of grants. Mechanically, it says average size of the award is $1.1-2.2 million – is that really the average?

Tom Land: Yes, that is the average. 12 awards, $44 Million at a minimum.

Keith Dunham: Can they potentially ask for more?

Tom Land: Yes, applicants could ask for more or less.

Keith Dunham: At the last meeting there was a discussion around geographic distribution of awards. Is geographic equality required or is that not a priority?

Tom Land: We are not required to consider it, but it will be a factor when considering awards. It is a factor to understand how it will work in rural, urban, suburban and different parts of the state. So it is important that we take that into consideration, and it will be a part of the review, but not the only piece.

Commissioner Bartlett: Yes, you can see that in the RFR, but we did not bring the whole RFR for you to review because of the potential conflict of interest.

Stephenie Lemon: Those are really wide ranges. I guess most will come in on the high side since we may just fund 6, so that is a consequence of such wide ranges.

Tom Land: We are aware that could be an issue. We talked about a smaller per person range, calculating what a likely award would be per population, but it is not in there right now. We are considering doing something along those lines.

Commissioner Bartlett: Perhaps we can supply some guidance per population.

Bruce Cedar: I did not see anything about evaluation. Does that mean DPH is going to take that over?

Commissioner Bartlett: Yes, it does. We will see a presentation shortly on our evaluation plan.

Susan Servais: Glad to see mental health comes up here as a comorbid condition, but it was talked about so much at the listening sessions, and I worry it is lost because it is not listed as a priority. I'm concerned about losing that.

Tom Land: We struggled with the fact that there is a delivery system for mental health, albeit one that is not well organized. We felt we could improve relationships between providers if we focused on this as a comorbidity.

Commissioner Bartlett: Is that going to be required?

Tom Land: No

Commissioner Bartlett: But a score might be better because that is included?

Tom Land: Yes, absolutely.

Lori Cavanaugh: So the population itself is weighted 40%, but the health intervention proposal itself is worth 20%. Can you speak about why that difference?

Tom Land: The discussion we had is around weighting. We should give quality of partnership and needs of population attention. It came down that roughly 60% should be on needs of populations and then how to address those needs. It is still under discussion, but in order to maximize the ROI, you must have a relatively high burden and interventions that will specifically address those burdens.

Commissioner Bartlett: So we have partnership 25% in first category and 10% in partnership infrastructure, so that is how those are different.

Tom Land: This is very much in flux, so if you have suggestions for how these will be scored, we are all ears.

Bruce Cedar: So is the 40% really where they are saying what they'll do or is that only 20%?

Tom Land: There is not a population in Massachusetts where all four of those conditions are represented somewhere, but with that 40%, we are trying to get away from something where an applicant has an artful grant writer who tells a good story. What we want is the level of need in those communities. An appendix in the RFR will be burden of all priority conditions, so they will know if it is high or low in their area. Those with high burden will have a higher score, but also need to see how they go about addressing it.

Paula Johnson: I'm waiting to see if interventions by burden makes sense for the reasons just stated, but a goal is to weight for the population. Do you think you can deliver the exact same message with different weighting in the scoring? Might say 40%, but see how partnership is adjusted and maybe reweight.

Commissioner Bartlett: Any other questions about what and how to present at bidders conference?

Lori Cavanaugh: One question you'll get is if the funding can move forward. If not used up, can we carry it forward?

Tom Land: The Commissioner mentioned a review every 6 months, and we'll tell them about their funding moving forward. They need to hit benchmarks or figure out how to move forward based on that. I'm just curious as to what the bidders' conference will be like. At the listening sessions, we had a lot of questions and a lot of people commenting.

Stephenie Lemon: What I guess, is that based on the folks in my community, is that there are concerns from smaller CBOs who do a lot of community work and are excited about this. There may be backlash because of the focus on secondary and tertiary interventions as opposed to prevention. You may need to be prepared to defend that.

Paula Johnson – If I understand correctly, all proposals must address all 4 conditions. My sense is that, for the amount of money, that is a pretty significant undertaking in 4 disparate areas. Tobacco could be connected with any, I suppose, but I think that is a lot to undertake for not a large amount of funding per awardee.

Susan Servais: I tend to agree with that. Some of them can be connected. You could have some initiatives that would hit easily on hypertension, asthma, tobacco, but then throw falls in there somehow. I'm concerned people will be making up ways to throw that in when it doesn't fit with the model. Could be a problem if requiring grant to have that.

Lisa Renee Holderby-Fox: I would echo that. As I looked at it the first time, I thought 3 of the 4 makes sense. I have to agree that there will be people at the bidders conference saying why all 4 when 3 fit neatly? Is there a way that maybe 2 of the 4 have to be hit? I don't know how to make it work.

Commissioner Bartlett: Good points.

Lori Cavanaugh: I wonder, but the one municipality could be an issue for large municipalities.

Tom Land: We are talking about population boundaries, so neighborhoods for larger cities, in which case the one application per neighborhood could apply.

Bruce Cedar: So with that line of thinking, could Boston or Worcester support more than one application?

Tom Land: Yes.

Stephenie Lemon: You mentioned the neighborhood idea. Are we thinking about these populations very strictly in terms of geography, when clinical systems have a broad reach?

Tom Land: I don't think we can think about defining it by a catchment area, but for our evaluation, it has to be that way. We would never say they cannot not offer services to a neighboring community.

Paula Johnson: I have to urge us to understand that patients do not live in one area. Health delivery organizations essentially are doing business around prevention, which is patient-focused and not community-focused. Really important point is that health care systems do not take care of community, they take care of people. Be really clear that it talks about taking care of the entire community, not just the people who walk through the door. Have to make that really clear.

Tom Land: The application is as long as it is because we are trying to get at what it means to be a partner in the community at large, as well as the health system. The Commissioner has used the word formalize: we are not trying to promote, rather we are trying to formalize the relationships.

Commissioner Bartlett: If you have any other questions, please get in touch with us.

PWTF and E-Referrals

Laura Nasuti, DPH Lead on E-Referrals

- Here to talk generally about e-referral and how it connects to PWTF
- Overall, it formalizes the linkage between clinical and communities by requiring an electronic link, but also working together, setting expectations around what e-referral should look like
- Evaluation – generates reports on number of referrals, services received, pounds lost (if weight loss is an intervention, for example)
- Once integrated, you can look at data population-wide. For example, do I see better A1C levels with referrals to diabetes program?
- There is a cost to initially integrate, but after that, the cost is being held by department because we are developing the program
- Community-based programs can make the case for clinical and financial effectiveness
- For PWTF, we are creating linkages, depending on the ability to link data back into medical records and services in community
- Sustainability has been an issue, but with this, having people talk more and setting up the electronic infrastructure for communication, that should improve

CMS State Innovation Testing Award

- In April 2013, Massachusetts was awarded the SIM Testing Award, part of which was to create an open-source, bi-directional e-referral program for community-clinical linkages
- The Massachusetts League of Community Health Centers is the primary partner
- Funding provides IT support and evaluation
- Pilot sites are affiliated with the Mass League, on CHIA DRVS, and have 4 community resources to link: tobacco quitline, Councils on aging, local VNAs, and YMCAs
- Part of CMS grant is to develop a rollout plan for the state. It is going to be open source, so anyone who wants to adopt the software, can adopt it.
- Example – patient starts with PCP, PCP refers to tobacco quitline and local CDSM, patient gives consent and e-referral initiated, referral accessed by community resource and they contact patient.

After patient receives services, the community service can send back information to clinic; there are multiple points of feedback and reports, and the provider will know what happens to the patients they refer

- To get a bit more technical, no matter what EMR system you're on, you can send information through our public software, and send to community resources
- Use-case development – potential end-users we've been meeting with to understand how they use the system: Mass League of Community Health Centers, Azara Healthcare, MassHIway, Executive Office of Elder Affairs, NICHQ
- Site visits: Joseph M. Smith CDC, Brockton Neighborhood Health Center, Southcoast Physicians Network, Hockomock Area YMCA, Old Colony YMCA
- Example referral types – tobacco cessation, VNA for transitions of care or wraparound services, YMCA, Councils on aging for CSDME and falls prevention
- For each referral we are conceptualizing the way info is transmitted by thinking about 4 buckets:
  - Patient information that can link back to EMR
  - Referring provider information
  - Referred to provider information
  - Referrer specific information
- There are 3 ways to initiate referrals using the system:
  - Via MassHIway, routed to appropriate community services automatically
  - If not MassHIway compliant, can submit to universal translator
  - Can also used staged referrals, so initiate in EMR, go to web-based portal and referral specialist or office manager can fill in detail and direct to resource
- Example of partially automated use case – pieces of information are being given to the system at each step – clinical setting, e-referral gateway, and CBO, in this case a council on aging
  - Allows for free text space to give reasons for why referral is happening or why patient did not complete
- We can start to talk about evaluation, so specific to e-referral, we can count the number of CHCs we've linked with, types of platforms we've done, # of referrals made, # of quit attempts, changes in A1C values, etc.
  - We can see who is receiving which services and how effective it might be
  - Look at efficacy and effectiveness of interventions – may have a great evidence-based intervention when patients attend all sessions, but do you get the same result when you only attend some? We can look at that.
  - Link health outcomes, identify reductions in disparities
  - Link claims data to look at cost-effectiveness and ROI

Questions from the Board regarding E-Referrals

Susan Servais: So for evaluation of the grants, they will have access to this system. Is it patient names or numbers? Says HIPAA compliant, but are names exposed?

Laura Nasuti: For evaluation purposes, we'd never need names. In fact, I'm not sure they will even be stored. In terms of the reports we could see, I don't think we'll get it.

Keith Dunham: This is powerful and really exciting, but laden with all this data floating around and the complexity of this from a security and privacy perspective cannot be underestimated.

Laura Nasuti: We are working with the Mass League and EOHHS IT product management, to ensure HIPAA compliance.

Marylynn Ostrowski: You'll need to be very upfront with how this information will be utilized and how it is explained to patients.

Tom Land: One of the appendices of the RFR will be data we are looking for.

Marylynn Ostrowski: Right, but when you have participants come in, you need to help them understand how the data is going to be used.

Laura Nasuti: You mean on the consent side?

Marylynn Ostrowski: Yes, that is very important.

Lisa Renee Holderby-Fox: The question I have is: Do the 4 priority conditions for the RFR match up to this CMS integration grant? If so, we need to make sure people know that was how those conditions were decided upon.

Commissioner Bartlett: It was not. This was developed to test community-clinical linkages.

Laura Nasuti: The quitline is statewide, VNA is local, YMCAs are both. Different community resources that have different networks, which is how they were chosen for the CMS grant. But we can pull out things here that are specific to PWTF, too.

Commissioner Bartlett: We are looking to create formalized linkage here.

Karen Regan: When a referral is made to an agency, will the entire patient records be sent? Or a decision made on a patient by patient basis?

Laura Nasuti: Yes, supposed to send the minimally appropriate information. Could just be contact info, or physical limitations, but definitely not an A1C level or information like that. That is not appropriate.

Commissioner Bartlett: A physician sends to the Y that a patient should participate in a CDSM program. The Y sends back what that patient did, and formalizes that feedback in a concrete way.

Stephenie Lemon: I'm wondering the extent to which technical assistance will be provided, particularly for non-clinical sites who are not used to handling this type of data. Thinking about my research background, anyone who is going to handle data would have to take a course to certify them to use the data.

Commissioner Bartlett: I'm not sure about certification, but we will provide TA.

Laura Nasuti: We are talking about having CMS grant services be a part of the business.

Peter Holden: Do patients have to verify every time to consent? I understand that is a problem with the MassHIway.

Tom Land: This is modeled after the tobacco quitline and has a double consent. Provider asks for consent, and then again when contacted by community resource.

Peter Holden: Every time I talk to providers I hear about the length of time consent adds; an incredible amount of times it adds for them.

Bruce Cedar: For an example, the physician sees someone, they say the patient should be referred, and they hear that the patient is showing up, enrolled, doing something. When it gets to evaluation, is it looking only at those that referred or what are we looking at regardless of what happens?

Laura Nasuti: This is going be a global evaluation, an evaluation of all services and small program evaluations. It is different than just e-referral versus those showing up, but can be does the walk-in population look different than those referred, and so on.

Bruce Cedar: So setting up these programs that will be self-standing and people can come from a lot of different places so we create linkages and providers make referrals to programs, so want high utilization of referrals as well as of programs.

Laura Nasuti: Yes

Stephenie Lemon: High utilization is critical. We have not talked about engagement and empowerment. Is there any way to build in the RFR that we are not just looking for a model, but looking for a way to engage and ensure use of these systems. A huge issue is not that we don't have programs, it is that people don't use them or don't care. That is a key part of how they put together their infrastructure.

Susan Servais: Bruce confused me. If we have a tobacco quitline, we want to know how those people that were referred to the program did, not how everyone in the program did.

Commissioner Bartlett: It is comparing those populations within the program.

Susan Servais: Is there a way of separating those referred because they are in the grant and those outside it?

Commissioner Bartlett: Yes.

Paula Johnson: How do we understand the aggregate of referrals from a community perspective? If higher rates of need seen, does that trigger a need for interventions? A broader community understanding of what it is that a community needs; the effect of this type of program on the community. Similar to the Breathe Easy program between BMC and Boston PHC around patient giving consent. There are ways this can be done

Evaluation Approach

Bonnie Andrews, Office of Eval and Statistics, DPH

- Start with outcome measures – healthcare cost savings, health equity – not just reduction and prevalence of conditions, but who is benefiting from the programs

- In addition, evaluation has to provide recommendations on where these should be expanded or contracted – focus on accountability
- Should we extend PWTF funding beyond 2016 or find other funding?
- Preparing annual report to legislature for funded communities
- Also responsible for helping grantees with data collection
    - We will contract to an expert with analysis in health care financing – looking forward to bringing them to the table
    - Provide data collection instruments and performance indicators
    - A system to connect clinical and community data
    - Provide TA for initiative and data collection
    - Increase forums for awardees to work together and learn from each other
- Also must evaluate in three domains: Community, Clinical, Community-Clinical Linkages
    - Schematic for overview – Community: policy, systems, environmental changes, Clinical: policy and systems changes improving quality and coordination of care, Community-Clinical Linkages: access to preventative and chronic services and promoting healthy behavior
- Certain questions in each sphere
    - Community:
        - Benefitting everyone in community?
        - Improved access for all residents?
        - Social capital and well-being changed?
        - Self-management improved?
        - Resources reporting back to provider?
    - Clinical:
        - Quality of data in EMR improving?
        - Quality of clinical encounters improved?
        - Increased access to preventive services?
        - Chronic condition management improved?
        - Ease of community referrals improved?
    - Linkages – 4 central questions:
        - Improved client follow-throughs?
        - Improved coordination of care?
        - Increased access to resources in community and clinical setting?
        - Improved screening of patients for chronic conditions?
    - Across them all, three questions:
        - Improved health outcomes?
        - Decreased health disparities?
        - Lowered health care costs?
- Linking the data across three sectors
    - Examples of data questions we might have or looking at in each domain:
        - Community: Increasing PA, consumptions of health foods, feelings of well being, community conditions?
        - Clinical: Providers asking about tobacco at every visit, control measures?

    - Linkages: Referrals to community resources increasing? Better health outcomes, improvement of disparities in health outcomes?
- By combing these, we can link across and see what is changing overall and for whom
- Example for falls prevention among older adults (in slides)

Questions from the Board regarding Evaluation

Lori Cavanaugh: I'm from CHIA, and what you've outlined here is impressive, but it is also ambitious to do this for each grantee across their conditions and domains, every 6 months. So how does this fit in with what bidders say they have to do versus just the department?

Bonnie Andrews: Some pieces the department is responsible for, but we'll also be providing TA on collecting data in communities, which is a part of sustainability. Tracking community-specific menu of interventions is tricky to merge with overall cost containment and outcomes evaluations, but we have had some experience doing that with success.

Commissioner Bartlett: We do have some resources from the law that enables us to hire people with skills or contractors to help with the initiative.

Lori Cavanaugh: To make sure I'm clear, what will grantees be required to do? I'm not clear on their responsibilities relative to DPH.

Bonnie Andrews: At a baseline level, grantees will agree to sign on to provide data elements. That will include different clinical elements and some community data, like asset mapping and community resources, those are some they will be responsible for. But sharing organizations' specific data with each other and sharing on either side in terms of how people are engaging in programs and making joint decisions.

Tom Land: I'd like to add one other thing. In the RFR, we're saying we want awardees to allocate at least 5% to evaluation and data collection. It is included in appendices, but a lot of this will be worked out in capacity-building in terms of what will be collected and how.

Stephenie Lemon: How will you define the universe for evaluation? You have the whole system on the clinical side and whole neighborhood and not everyone involved in everything will be able to participate. It is useful to think through what those parameters will be to make sure those macro-level points don't get lost along the way.

Susan Servais: This kind of example would be very helpful at the bidders' meetings to show to them. Also helpful for some of the other priorities to set up the same sort of algorithm and how we might evaluate on the community and linkages. Some examples like this are helpful for the bidders' conference.

Lori Cavanaugh: Bidders will also want to know that specific outcomes will be required. I suspect bidders will be very concerned with what those outcomes will be and what will be linked to each of them.

Tom Land: The only thing I will add is that the RFR is to be posted next Monday. So if you have any additional comments, send to me or the team ASAP. We need to get this to POS at the end of this week, but are happy to and interested in hearing more.

Closing

Commissioner Bartlett: If there are no other comments, we are done early. The next meeting is here Sept 26th, and we'll be recruiting for review of applications.

Tom Land: By September 26th, we will have received the letters of intent, so can give you a sense of where the intended applicants are coming from.

Commissioner Bartlett: We would also like to have Tom present on the evaluation we've been doing for MIM so you get a sense of the type of complexity we have been working with and how we can start to do this.

Consensus to adjourn at 2:35 pm.